PRINTED: 01/27/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAL OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 295072 01/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. SILVER RIDGE HEALTHCARE CENTER LAS VEGAS, NV 89146 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey: CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations. 200 per condidation actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified: F 279 483.20(d), 483.20(k)(1) COMPREHENSIVE F 279 CARE PLANS SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's RECEIVED medical, nursing, and mental and psychosocial

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

highest practicable physical, mental, and

needs that are identified in the comprehensive

The care plan must describe the services that are

to be furnished to attain or maintain the resident's

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LAS YEGAS, NEVADA

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

assessment.

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICALI ERVICES					PRINTED: 01/27/2009 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		295072	B. WING		01/1	6/2009
NAME OF F	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COI	DE	
SILVER	RIDGE HEALTHCARE	CENTER		1151 TORREY PINES DR. LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	psychosocial well-b §483.25; and any s be required under § due to the resident's \$483.10, including tunder §483.10(b)(4). This REQUIREMENT by: Based on observation review, the facility facomprehensive cardinaries include: 1. Resident #1 was 1/6/09 with diagnost Failure, Osteoarthrist Artery Disease, and Pulmonary Disease. Resident #1 was addindwelling Foley cattresident's Nursing Adated 1/6/09. From #1 was observed to yellow urine present. At 11:00 AM on 1/16 Consultant indicated indwelling Foley cattresident's a Catheter Nelan form was compared to the present.	eing as required under ervices that would otherwise (483.25 but are not provided is exercise of rights under the right to refuse treatment). IT is not met as evidenced on, interview and record alled to develop a explan for 1 of 24 sampled admitted to the facility on essincluding Congestive Heart its, Atrial Fibrillation, Coronary Chronic Obstructive mitted to the facility with an enter as documented on the admission Assessment form 1/13 to 1/16/2009, Resident have a Foley catheter with	F 27	-	n & care for this ents with acted on d a catheter an form in ill audit all day, all have a atheter plan form I nurses 19 on the valuation & the P & P. random vith foley r need rms are in	

care plan.

indicated the form also acted as the resident's

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		IDENTIFICATION NUMBER:	A. BUIL	DING	(X3) DATE COMP	SURVEY PLETED
		295072	B WING	3	01/	/16/2009
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP (1151 TORREY PINES DR. LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETION DATE
F 279	}	ge 2 dence a Catheter Need	F 27	79		
F 315 SS=D	Evaluation and Care Resident #1. On 1/2 Director of Nursing not have a catheter	e Plan form was completed for 16/2009 in the afternoon, the confirmed Resident #1 did assessment completed and -rer care plan initiated.	F 31	15		
	assessment, the factoresident who enters indwelling catheter is resident's clinical contact catheterization was who is incontinent of treatment and service.	ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the indition demonstrates that necessary; and a resident f bladder receives appropriate ces to prevent urinary tract store as much normal bladder		F315 Resident #1 dis the facility on 1/23/09. A catheter need evalua plan form was complet resident on 1/16/09. A 100% audit of all resident catheters was con 1/20/09. All residents need evaluation & care	tion & care ed for this idents with ducted on had a catheter	
2	by: Based on observation review, the facility faindwelling catheter uncatheter care for 4 of #21, #12, #19). Finding include: 1. Resident #1 was a	T is not met as evidenced on, interview, and record iled to medically justify ise and provide appropriate f 24 sampled residents (#1,		place. Nursing administration new orders each busine foley catheter orders with chart review to ensure a need evaluation and car was completed. Licens were inserviced on 1/20 use of the catheter need	will audit all ss day, all all have a catheter e plan form ed nurses 0/09 on the evaluation &	
	Osteoarthritis, Atrial Disease, and Chroni Disease. Resident #1 was adr	Congestive Heart Failure, Fibrillation, Coronary Artery c Obstructive Pulmonary nitted to the facility with an		DON or designee to do chart check of residents catheter to ensure order and report to CQI comm	a random with foley s are in place	
		eter as documented on the dmission Assessment form		throughout the year.		01-20-09

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/16/2009	
	295072		B. WI	NG _			
	PROVIDER OR SUPPLIER	CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315	#1 was observed to yellow urine present At 11:00 AM on 1/10 Consultant indicated indwelling Foley cat facility, a Catheter N Plan form was completed for the catheter. The	1/13 to 1/16/2009, Resident have a Foley catheter with	F	315		-	
	Evaluation and Care Resident #1. On 1/1 Director of Nursing not have a catheter no indwelling cathet 2. Resident #21 was with diagnoses inclu Tract Infection, Mus	dence of a Catheter Need e Plan form was completed for 6/2009 in the afternoon, the confirmed Resident #1 did assessment completed and er care plan initiated. s admitted on 12/17/2008, iding Pneumonia, Urinary cle Weakness, Hypertension,			Resident #21—An order for the foley catheter was obtained or 1/16/09. An audit of 100% of residents with foley catheters conducted on 1/20/09. Nursing administration will audit all no orders each business day, all for the following strates.	n Fall was ng	
	as documented on the Assessment form date of 1/16/2009, Resident Foley catheter with y Foley bag. There was no docume at 1 had an order for the form dated 12/17/08	dmitted with a Foley catheter he Nursing Admission ated 12/17/2008. From 1/13 to #1 was observed to have a rellow urine present in the mented evidence Resident a Foley catheter. Resident I Evaluation and Care Plan			catheter orders will have a chareview to ensure that all order obtained to manage said cathe Licensed nurses were inservice 1/20/09 on the foley catheter I DON or designee to do a rand chart check of residents with a catheter to ensure medical justification and catheter management plan are in place report to CQI committee throuthe year.	art s were eter. eed on P & P. om foley and	01-20-09

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		AND HUMAN SERVICES			FORM	: 01/27/200 APPROVE
CENTERS FOR MEDICARE & MEDICA! ERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL	TIPLE CONSTRUCTION NG	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
		295072	B WING		01/1	6/2009
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
SILVER	RIDGE HEALTHCARE	CENTER		1151 TORREY PINES DR. LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	(Medical Doctor) ord There was no docur #21 had specific phy catheter care and m At 11:00 AM on 1/16 Consultant indicated needed for Foley can Physician orders we and maintenance for indwelling catheter. 3. Resident #12 was resident initially admand recently re-admandiagnoses including Stomach Cancer, Unstaphylococcus Auro Vancomycin-Resistat Weakness, Impaired Obstructive Pulmona Breath, and Chronic The History and Phy 2/19/08 and 9/3/08, oclosed records indicating diagnosis which reverequired an indwellin The resident had a the The Nursing Admissi 1/7/09, indicated the	mented evidence Resident visician orders for Foley laintenance. 6/2009, the Regional Director of physician orders were theter insertions. Also, are needed for specific care or each resident who had an each resident who h	F 315	Resident#12—Foley catheter removed on 1/14/09. An aut 100% of all residents with ficatheters was conducted on All residents had a catheter evaluation & care plan form Nursing administration will new orders each business da foley catheter orders will have chart review to ensure a cather need evaluation and care plan was completed. Licensed nuwere inserviced on 1/20/09 ouse of the catheter need evaluation as well as the DON or designee to do a ran	ndit of oley 1/20/09. need in place. audit all y, all we a neter n form arses on the uation & P & P. dom	
	dinanacia ivas cijida:	t in the engage provided for		chart check of residents with	roiey	

its use.

from Valley Hospital with a Foley Catheter and no diagnosis was evident in the space provided for

As noted in the facility's nursing assessment,

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catheter to ensure all forms and

orders are in place and report to CQI committee throughout the year.

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01-20-09



4	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICA ERVICES				FORM	: 01/27/2009 I APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUIL		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
_		295072	B. WIN	G		01/1	6/2009
NAME OF PROVIDER OR SUPPLIER SILVER RIDGE HEALTHCARE CENTER				11	REET ADDRESS, CITY, STATE, ZIP CODE 151 TORREY PINES DR. AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION :		OULD BE	(X5) COMPLETION DATE
F 315	when a resident is a	admitted with a Foley Catheter, d with catheter orders and	F3	15			
	Management document the resident was a pre-training or individed bladder re-training, document indicated the resident's currer indwelling catheter, page that the reside	el & Bladder Assessment and nent dated 1/7/09, indicated possible candidate for ual training for bowel and/or. The two page assessment no documented evidence of at status of having an It was noted on the second and the second and the second are mode for the resident.					
	indicated the resider included a plan to ac intravenous antibioti therapy/occupationa treatment to improve	is Note dated 1/8/09, and is initial assessment dimit the resident to the facility, cs, PT/OT (physical I therapy) evaluation and the patient's functional ence, and nutritional support.					
	noted, but not reada	ce in the assessment which					
	word "Foley" under E the plan). There was	m Plan of Care indicated the Bladder/Bowel Status (#6 in no plan of care or directions mented in the plan of care.				İ	

4. Resident #19 was a 90 year-old female resident initially admitted on 11/12/08 and recently re-admitted on 1/8/09, with diagnoses including Depression, Dementia, Hypertension,

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	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICA ERVICES			FORM	0: 01/27/2009 1 APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		295072	B. WING		01/1	16/2009
	ROVIDER OR SUPPLIER	CENTER		TREET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Coronary Artery Dis Failure, Muscle Web Dysphagia, Symbolic Colitis, Metabolic My Chronic Gastritis, D Renal Insufficiency, Hypernatremia, and The current History dated 1/9/09, indicated and the fasouthern Hills Hosp There was no mentifind welling catheter arequired the resident The Nursing Admiss 1/8/09, indicated a Fupon the resident's rediagnosis was evide its use. The facility's Medica following the re-admit/8/09 for Foley Cathwas diagnosis indicated the use of care required. The resident's Interir indicated the word "F" Toileting" section. He documented evidence directions of care for of care.	ease, Congestive Heart akness, Gait Impairment, c Dysfunction, C. Difficile yopathy, Recurrent Falls, iverticulitis, Osteoarthritis, Hyperkalemia, Anemia. and Physical Examination ted the resident was icility following a transfer from ital due to chest congestion. on of the resident having an ind/or diagnosis which t to have a catheter.	F 315	Resident#19—Foley catheter removed on 1/14/09. An aud 100% of all residents with for catheters was conducted on All residents had a catheter revaluation & care plan form Nursing administration will a new orders each business day foley catheter orders will have chart review to ensure a cather need evaluation and care plan was completed. Licensed nowere inserviced on 1/20/09 of use of the catheter need evaluation as well as the DON or designee to do a ranchart check of residents with catheter to ensure all forms a orders are in place and report committee throughout the year.	dit of oley 1/20/09. Heed in place. He audit all y, all ye a heter in form hirses on the heation & P & P. Hodom in foley and to CQI	01-20-09

Catheter. This order was written following an

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AND PLAN OF CORRECTION IDENTIFICATION NUMBE		A. BUILDING			COMPLETED	
	295072	B. WIN	IG _	 -	01/1	6/2009
	CENTER		11	151 TORREY PINES DR.		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
interview (1/13/09) v reasons why Reside catheter.	with nursing staff into the ent #19 had an indwelling			checked the dishwasher on to morning of 1-13-09 and the	the	
considered satisfact authorities; and (2) Store, prepare, of	ory by Federal, State or local			functioning correctly. The dietary staff on duty was serviced on the use of the diand how to check the machine chlorine based system. Addiservices were done on 1-22-02-06-09. Diet Tech will check daily the	s in- shwasher ne's tional in- 09 and	
by: Based on observation facility failed to serve conditions. Findings include: On 1/13/09, a tour of	ons and record review, the e food under sanitary			machine maintains 50 parts particularly million residual chlorine level Dietary Supervisor or design randomly monitor procedure training, ensuring the dish lo	per els. ee will of g is	02-06-09
1. The chlorine based chemical dishwasher was tested three times for chlorine with the facilities chlorine test strips and failed to produce the minimum 50 parts per million (ppm) residual chlorine level. The chlorine test log indicated that the last chlorine test was done on 1/11/09. Note: The dishwasher service company came out to the facility and repaired the dishwasher on 1/13/09, after being brought to the attention of the facility.				in refrigerator were covered. Dietary staff was in-serviced policy and procedure to cover plated foods stored in the wall Evening cook will check refri before leaving to ensure foods properly covered/dated. Dietary supervisor or designed monitor this procedure on a ra	on /date k-in. gerator s are will ndom	01-22-09
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From parinterview (1/13/09) yreasons why Reside catheter. 483.35(i) SANITAR' The facility must - (1) Procure food fro considered satisfact authorities; and (2) Store, prepare, ounder sanitary cond This REQUIREMENT by: Based on observation facility failed to serve conditions. Findings include: On 1/13/09, a tour of the following deficient. 1. The chlorine base tested three times for chlorine test strips and minimum 50 parts per chlorine level. The condition of the last chlorine test. Note: The dishwash out to the facility and 1/13/09, after being it.	RIDGE HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 interview (1/13/09) with nursing staff into the reasons why Resident #19 had an indwelling catheter. 483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to serve food under sanitary conditions. Findings include: On 1/13/09, a tour of the kitchen area revealed the following deficiencies: 1. The chlorine based chemical dishwasher was tested three times for chlorine with the facilities chlorine test strips and failed to produce the minimum 50 parts per million (ppm) residual chlorine level. The chlorine test log indicated that the last chlorine test was done on 1/11/09. Note: The dishwasher service company came out to the facility and repaired the dishwasher on 1/13/09, after being brought to the attention of the	PROVIDER OR SUPPLIER RIDGE HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 interview (1/13/09) with nursing staff into the reasons why Resident #19 had an indwelling catheter. 483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to serve food under sanitary conditions. Findings include: On 1/13/09, a tour of the kitchen area revealed the following deficiencies: 1. 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Note: The dishwasher service company came out to the facility and repaired the dishwasher on 1/13/09, after being brought to the attention of the	RIDGE HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 interview (1/13/09) with nursing staff into the reasons why Resident #19 had an indwelling catheter. 483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to serve food under sanitary conditions. Findings include: On 1/13/09, a tour of the kitchen area revealed the following deficiencies: 1. 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Note: The dishwasher service company came out to the facility and repaired the dishwasher on 1/13/09, after being brought to the attention of the	RIDGE HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRINT CARD DEFICIENCY (IT AG)	ROVIDER OR SUPPLIER RIDGE HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 interview (1/13/09) with nursing staff into the reasons why Resident #19 had an indwelling catheter. 483.35(i) SANITARY CONDITIONS The facility must (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to serve food under sanitary conditions. Findings include: On 1/13/09, a tour of the kitchen area revealed the following deficiencies: 1. The chlorine based chemical dishwasher was tested three times for chlorine with the facilities chlorine test strips and failed to produce the minimum 50 parts per million (ppm) residual chlorine level. The chlorine test story is million residual chlorine level is within standard levels 1. The chlorine based chemical dishwasher was tested three times for chlorine with the facilities chlorine test strips and failed to produce the minimum 50 parts per million (ppm) residual chlorine level. The chlorine test log indicated that the last chlorine test was done on 1/11/09. Note: The dishwasher service company came out to the facility and repaired the dishwasher on 1/13/09, after being brought to the attention of the

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		AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAL ERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE S	. 0938-0391
		IDENTIFICATION NUMBER	A. BUI			COMPLE	
		295072	B. WII	1G _		01/1	6/2009
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SILVER	RIDGE HEALTHCARE	CENTER			151 TORREY PINES DR. .AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 8	F	371	3. The broken light bulb four	nd in the	
	i .	esidents in the walk-in	,	i	walk-in refrigerator was repa immediately.	ired	
	There was a broken light bulb in the walk-in refrigerator.				The dietary supervisor did a safety walk-through of the dietary department to determine if any oth		
F 431	4. The hand wash sink by the dishwasher was not secured to the wall. 483 60(b), (d), (e) PHARMACY SERVICES		F	31	lights were out, broken, or needed any repair.		
F 431 483.60(b), (d), (e) PHARMACY SERVICES SS=D The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.		, ,		Weekly safety walk-through done by the Diet Tech and rewill be made as needed. The Dietary Supervisor or dwill monitor this process will weekly spot checks and repeared areas of concern during CQI meetings.	epairs esignee th ort any	01-22-09	
	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.				4. The hand washing sink was secured to the wall. The dietary supervisor compasafety walk-through of the edepartment to identify any a needed repair.	oleted a ntire reas	
40 V	In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.				The diet tech will do a weekly safety walk-through of the dietary department noting any needed repairs and notify the maintenance department.		
	The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to			į	The Dietary Supervisor or de will monitor dietary departm safety issues with periodic sy checks and report any areas	ent pot	

Control Act of 1976 and other drugs subject to

abuse, except when the facility uses single unit package drug distribution systems in which the

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challenge during CQI/QA.

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PRINTED: 07/2//2009



		AND HUMAN SERVICES & MEDICA ERVICES			PRINTED: 01/2//2009 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SÚPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUI A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		295072	B. WING		01/16/2009
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
SILVER	RIDGE HEALTHCARE	CENTER		1151 TORREY PINES DR. LAS VEGAS, NV 89146	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPRINCED TO THE APPRINC	ULD BE COMPLETION
F 431		ge 9 inimal and a missing dose can	F 43	1	
	by: Based on observation	on, the facility failed to ensure were discarded in a timely			
	box in the Medicatio contained: a) a one milliliter vial per milliliter) with an b) seven one millilite milligrams per millilite 4/08; and c) four one milliliter vial	PM, the locked medication n Room #1 refrigerator of Lorazepam (2 milligrams expiration date of 11/07; or vials of Lorazepam (2 er) with an expiration date of vials of Lorazepam (2 er) with an expiration date of er) with an expiration date of		F431—The medications were removed on 1/14/09. License nursing staff was inserviced of 1/20/09 on the storage of narch All medication refrigerators with inspected and no medications currently stored in the lock both of 1/20/09. Nursing administration will convert weekly inspections of the narch lock boxes in the refrigerators any medications that are expirately were prescribed for a currently were prescribed for	ed on cotics. vere are oxes as onduct cotic s for ced or
	Note: The vials with the expiration date of 4/08 were intermingled with two vials displaying an expiration date of 2011, in a small "ziplock" bag. On 1/14/09 at 3:45, Employee #1 acknowledged the vials had expired and should have been removed and discarded on the last day of the month on the label.			were prescribed for a currently discharged patient. DON or designee to monitor by random inspection of narcotic boxes and report to CQI throuthe year.	by lock

Event ID: Q43211

Facility ID: NVS2340SNF

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